TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Emily D. Friedman, M.D.

Respondent Name
Arch Insurance Company

MFDR Tracking Number
M4-16-3540-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
July 26, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "I have not yet been paid for my 4/16/15 initial visit, my 6/16/15 visit, my 7/20/15 visit, my 10/26/15 visit, my 11/30/15 visit, my 1/21/16 visit or my 2/22/16 visit."

Amount in Dispute: $1,585.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "… we have escalated the bills in question for manual review to determine if additional monies are owed."

Response Submitted by: Gallagher Bassett

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 16, 2015 – February 22, 2016	Evaluation and Management Examinations	$1,585.00	$319.52

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.240 sets out the guidelines for billing designated doctor examinations.
3. 28 Texas Administrative Code §134.203 sets out the fee guidelines for professional medical services.
4. Texas Labor Code Sec. 408.027(b) defines the requirements for payment of a health care provider.
5. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 150 – Payer deems the information submitted does not support this level of service.
   - 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.

- P12 – Workers' compensation jurisdictional fee schedule adjustment.
- 112 – Service not furnished directly to the patient and/or not documented.

Issues

1. Did the requestor waive the right to medical fee dispute resolution for dates of service April 16, 2015; June 16, 2015; and July 20, 2015?
2. Did Arch Insurance Company (Arch Insurance) take final action to pay, reduce, or deny the disputed services not later than the 45th day after receiving the medical bill?
3. Are Arch Insurance's denials of payment for level of service supported?
4. Is Dr. Friedman entitled to reimbursement for the services in question?

Findings

1. Dr. Friedman is also seeking reimbursement, in part, for evaluation and management services performed on April 16, 2015; June 16, 2015; and July 20, 2015. 28 Texas Administrative Code §133.307(c)(1) states:

   > Timeliness. A requestor shall timely file the request with the division's MFDR Section or waive the right to MFDR. The division shall deem a request to be filed on the date the MFDR Section receives the request. A decision by the MFDR Section that a request was not timely filed is not a dismissal and may be appealed pursuant to subsection (g) of this section.
   >
   > (A) A request for MFDR that does not involve issues identified in subparagraph (B) of this paragraph shall be filed no later than one year after the date(s) of service in dispute.

   The dates of the service in question are April 16, 2015; June 16, 2015; and July 20, 2015. The request for this dispute was received in the Medical Fee Dispute Resolution (MFDR) Section on July 26, 2016. This date is later than one year after the dates of service in question. Review of the submitted documentation finds that the disputed services do not involve issues identified in §133.307(c)(1)(B). The division concludes that the requestor has failed to timely file a dispute for these dates of service with the division's MFDR Section. Consequently, the requestor has waived the right to medical fee dispute resolution for the dates in question.

2. Dr. Friedman is also seeking reimbursement, in part, for evaluation and management services performed on January 21, 2016. Submitted documentation finds no explanations of benefits were submitted by either party for this date of service.

   According to Texas Labor Code Sec. 408.027(b), Arch Insurance was required to pay, reduce, or deny the disputed services not later than the 45th day after it received the pharmacy bill from Dr. Friedman. Corresponding 28 Texas Administrative Code §133.240(a) also required Arch Insurance to take **final action** by issuing an explanation of benefits not later than the statutorily-required 45th day. 28 Texas Administrative Code §133.2(6) defines final action as follows:

   > (6) Final action on a medical bill—
   >
   > (A) sending a payment that makes the total reimbursement for that bill a fair and reasonable reimbursement in accordance with §134.1 of this title (relating to Medical Reimbursement); and/or
   >
   > (B) denying a charge on the medical bill.

   Arch Insurance was not relieved of its requirement to pay, reduce, or deny the disputed services not later than the 45th day after it received the medical bill from Dr. Friedman, in accordance with Texas Labor Code Sec. 408.027(b). When the insurance carrier receives a medical bill, it is obligated to take the following actions pursuant to 28 Texas Administrative Code §133.240:

   > (a) An insurance carrier **shall take final action** [emphasis added] after conducting bill review on a complete medical bill…**not later than the 45th day** [emphasis added] after the insurance carrier received a complete medical bill…
   >
   > (e) The insurance carrier **shall send the explanation of benefits** [emphasis added] in accordance with the elements required by §133.500 and §133.501 of this title…The explanation of benefits shall be sent to:

(1) the health care provider when the insurance carrier makes payment or denies payment on a medical bill…

All workers' compensation insurance carriers are expected to fulfill their duty to take final action as required by the division's statutes and adopted administrative rules. The division finds that:

- no evidence was presented to the division to support that Arch Insurance took final action by paying, reducing, or denying the services in dispute within 45 days; and
- no evidence was presented to the division to support that Arch Insurance timely presented ***any*** defenses to Dr. Friedman on an explanation of benefits as required under 28 Texas Administrative Code §133.240 prior to the request for medical fee dispute resolution.

Absent any evidence that Arch Insurance raised any defenses that conform to the requirements of Title 28, Part 2, Chapter 133, Subchapter C, the division finds that the services in question will be reviewed in accordance with applicable fee guidelines.

3. Dr. Friedman is also seeking reimbursement, in part, for evaluation and management services performed on October 26, 2015; November 30, 2015; and February 22, 2016. 28 Texas Administrative Code §134.203(b)(1) states, in pertinent part,

> for coding, billing reporting, and reimbursement of professional medical services, Texas Workers' Compensation system participants shall apply the following:
> (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; … and other payment policies in effect on the date a service is provided…

Review of the submitted documentation finds that Dr. Friedman performed office visits for the evaluation and management of an established patient on the dates of service in question. The American Medical Association (AMA) CPT code description for 99214 is:

> Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: **A detailed history; A detailed examination; Medical decision making of moderate complexity**. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 25 minutes are spent face-to-face with the patient and/or family. [emphasis added]

The 1995 Documentation Guidelines for Evaluation & Management Services is the applicable Medicare guideline to determine the documentation requirements for the service in dispute. Required components for documentation of CPT Code 99214 are as follows:

- Documentation of the Detailed History:
  - "An *extended* [History of Present Illness (HPI)] consists of at least four elements of the HPI."
  - "An *extended* [Review of Systems (ROS)] inquires about the system directly related to the problem(s) identified in the HPI and a limited number of additional systems. [Guidelines require] the patient's positive responses and pertinent negatives for two to nine systems to be documented."
  - "A *pertinent* [Past Family, and/or Social History (PFSH)] is a review of the history area(s) directly related to the problem(s) identified in the HPI. [Guidelines require] at least one specific item from any three history areas [(past, family, or social)] must be documented…"

  The Guidelines state, "To qualify for a given type of history, **all three elements in the table must be met.**"
- Documentation of a Detailed Examination:
  - A "*detailed examination* – an extended examination of the affected body area(s) and other symptomatic or related organ system(s)." The Guidelines state, "Specific abnormal and relevant negative findings of the examination of the affected or symptomatic body area(s) or organ system(s) should be documented. A notation of 'abnormal' without elaboration is insufficient."
- Documentation of Decision Making of Moderate Complexity:

- *Number of diagnoses or treatment options* – The number of problems, whether the problem is diagnosed, and types of diagnostic testing recommended are taken into account.
- *Amount and/or complexity of data to be reviewed* – This can include diagnostic tests ordered or reviewed and data reviewed from another source.
- *Risk of complications and/or morbidity or mortality* – "The highest level of risk in any one category (presenting problem(s), diagnostic procedure(s), or management options) determines overall risk."

"To qualify for a given type of decision making, **two of the three elements … must be either met or exceeded**."

For date of service October 26, 2015, the submitted documentation supports that Dr. Friedman provided a review of seven elements of HPI, a review of two systems, and two elements of PFSH. This meets the documentation requirements for a detailed history. The submitted report shows that Dr. Friedman included performance and documentation of a problem focused examination of the affected body area and other symptomatic areas, which does not meet the criteria for a detailed examination. The submitted documentation supports that Dr. Friedman met the criteria for documentation of decision making of low complexity. **Because the documentation indicates that Dr. Friedman met only one of the required key components of CPT code 99214, this level of service is not supported.**

For date of service November 30, 2015, the submitted documentation supports that Dr. Friedman provided a review of six elements of HPI, a review of two systems, and three elements of PFSH. This meets the documentation requirements for a detailed history. The submitted report shows that Dr. Friedman included performance and documentation of a problem focused examination of the affected body area and other symptomatic areas, which does not meet the criteria for a detailed examination. The submitted documentation supports that Dr. Friedman met the criteria for documentation of decision making of moderate complexity. **Because the documentation indicates that Dr. Friedman met at least two of the required key components of CPT code 99214, this level of service is supported.**

For date of service February 22, 2016, the submitted documentation supports that Dr. Friedman provided a review of five elements of HPI, a review of two systems, and one element of PFSH. This does not meet the documentation requirements for a detailed history. The submitted report shows that Dr. Friedman included performance and documentation of a problem focused examination of the affected body area and other symptomatic areas, which does not meet the criteria for a detailed examination. The submitted documentation supports that Dr. Friedman met the criteria for documentation of decision making of straight-forward complexity. **Because the documentation indicates that Dr. Friedman met only one of the required key components of CPT code 99214, this level of service is not supported.**

4. 28 Texas Administrative Code §134.203(c) states,

> To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications.
> (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is $52.83…
> (2) The conversion factors listed in paragraph (1) of this subsection shall be the conversion factors for calendar year 2008. Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors, and shall be effective January 1st of the new calendar year…

The Medicare fee is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by the conversion factor. The maximum allowable reimbursement (MAR) is calculated by substituting the division conversion factor. The division conversion factor for 2015 is $56.20. The division conversion factor for 2016 is $56.82.

For procedure code 99214 on November 30, 2015, the relative value (RVU) for work of 1.5 multiplied by the geographic practice cost index (GPCI) for work of 1.0 is 1.5. The practice expense (PE) RVU of 1.43 multiplied

by the PE GPCI of 0.872 is 1.24696. The malpractice (MP) RVU of 0.1 multiplied by the MP GPCI of 0.845 is 0.0845. The sum of 2.83146 is multiplied by the division conversion factor of $56.20 for a MAR of $159.13.

For procedure code 99214 on January 21, 2016, the relative value (RVU) for work of 1.5 multiplied by the geographic practice cost index (GPCI) for work of 1.0 is 1.5. The practice expense (PE) RVU of 1.42 multiplied by the PE GPCI of 0.872 is 1.23824. The malpractice (MP) RVU of 0.1 multiplied by the MP GPCI of 0.845 is 0.0845. The sum of 2.82274 is multiplied by the division conversion factor of $56.82 for a MAR of $160.39.

The total allowable for the services in dispute is $319.52. This amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $319.52.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031 and 413.019 (if applicable), the division has determined the requestor is entitled to additional reimbursement for the disputed services. The division hereby ORDERS the respondent to remit to the requestor $319.52, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

	Laurie Garnes	October 27, 2017
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with Rule §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.